



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDICAL CENTER EMERGENCY PHYSICIANS
PO BOX 4590 DEPARTMENT 6
HOUSTON TX 77210

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-4684-01

MFDR Date Received

AUGUST 10, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our office feels that the carrier is responsible for this bill because under EMTALA hospitals with emergency departments are required to provide appropriate medical screening examinations of patients seeking examination or treatment for a medical condition to determine whether or not an *emergency medical condition* exists, therefore our office should not be penalized because the carrier thinks the patient's visit was not sever [sic] enough to be treated in an emergency room."

Amount in Dispute: \$383.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor's documentation simply does not support a medical emergency as defined by Rule 133.2. Texas Mutual argues the claimant had a reasonable opportunity to contact the treating doctor at least by telephone. If at that point the treating doctor had instructed the claimant to go to the nearest emergency department then there would be some support for the requestor's assertion Texas Mutual is liable for the costs of the requestor's treatment. For these reasons no payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 20, 2011	CPT Code 99283	\$300.00	\$0.00
	CPT Code 29530	\$83.00	\$0.00
TOTAL		\$383.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Texas Labor Code §408.021, effective September 1, 1993, requires all treatment, except in emergencies, to be

approved by the treating doctor.

3. 28 Texas Administrative Code §133.2, effective July 27, 2008, defines a medical emergency.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- CAC-W1-Workers compensation state fee schedule adjustment.
- CAC-18-Duplicate claim/service.
- 878-Appeal (Request for reconsideration) previously processed. Refer to rule 133.250(H).
- 899-Documentation and file review does not support an emergency in accordance with rule 133.2.
- CAC-B7-This provider was not certified/eligible to be paid for this procedure/service on this date of service.
- 242-Not treating doctor approved treatment.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 891-No additional payment after reconsideration.

Issues

1. Does the documentation support a medical emergency?
2. Did the treating doctor approve the disputed treatment?

Findings

1. The insurance carrier denied reimbursement for the disputed emergency room services based upon reason code "899."

The requestor states in the position summary that "According to the ER notes this patient was seen at the emergency room for server [sic] constant knee pain that the patient rates an 8 on a scale from 0-10, knee strapping was applied to her right leg."

28 Texas Administrative Code §133.2 (3) defines "Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

- (i) placing the patient's health or bodily functions in serious jeopardy, or
- (ii) serious dysfunction of any body organ or part."

A review of the Emergency Department Record finds the following:

- "ADMISSION: Urgency: 4-Non-Urgent.
- ASSESSMENT: she has been suffering from an exacerbation of right knee pain which has been a chronic issue for the past 5 years now.
- PAIN: patient rates pain as 8, right knee.
- TRIAGE CARE: No triage treatment given.
- CONSTITUTIONAL: Patient arrives ambulatory with steady gait to treatment area...Patient appears comfortable...appears in no acute distress.
- RIGHT LOWER EXTREMITY: Pedal pulses present, Brisk capillary refill, Sensation intact, Patient denies numbness/tingling, Popliteal pulse present, No external rotation, No shortening, Homan's sign negative, Area of assessment is knee, Pain described as sharp, On a scale 0-10 patient rates pain as 8, Swelling, Pt. states heard funny sound from R knee while exiting vehicle yesterday. Pt. noted swelling with pain last night.
- DISCHARGE NOTE: Patient discharged to, home, Transported via patient driving, Patient unaccompanied."

The Division finds that the documentation does not support a medical emergency as defined in 28 Texas Administrative Code §133.2 (3); therefore, the respondent's denial of reimbursement based upon reason code "899" is supported.

2. The insurance carrier denied reimbursement for the disputed emergency room services based upon reason code "242."

Texas Labor Code 408.021(c) states "Except in an emergency, all health care must be approved or recommended by the employee's treating doctor."

On the disputed date of service, the claimant's treating doctor was Jorge Velez.

The documentation does not support that the disputed treatment was approved or recommended by the employee's treating doctor; therefore, the disputed services were not in compliance with Texas Labor Code 408.021(c). Therefore, the respondent's denial based upon reason code "242" is supported.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	8/8/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.